☐ Department of Labor & Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

☐ Department of Labor & Industries
Self-Insurance
PO Box 44892
Olympia WA 98504-4892

REQUEST FOR CLAIM INFORMATION

(To be completed by worker, worker's representative employer, or employer's representative)

This form must be completed in full

Claim No.

Worker's name

Name of person making request ☐ Worker ☐ Other Date Phone

Address

City State ZIP

Copies of documents are a chargeable item

Please check the proper box(s).

☐ I am requesting my claim file.

☐ I am requesting the following information from my claim file:
(for example, "the panel exam of Feb 4, 1977," etc.) Please list below.

☐ I am the worker's authorized representative requesting the claim file for the worker named above. I understand that the file contains confidential information and by accepting the file, I accept full responsibility for any use made of this information. AUTHORIZATION IS:

☐ ON FILE ☐ ATTACHED

☐ I am the employer or employer's representative requesting the claim file for the worker named above. I understand that the file contains confidential information and by accepting the file, I accept full responsibility for any use made of this information.

Signature

For Department use only:

Action taken on request

Date action taken	Name of person taking the action	Section/office

F101-010-111 (PDF) request for claim information 2-00